FOR OHF USE

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005397

Facility Name: La Moine Christian Nursing Home

Address: 145 South Chamberlain - Box 770 (Number) Roseville (City) 61473-0770 (Zip Code)

County: Warren

Telephone Number: 309-462-2134 **Fax #** ( )

IDPA ID Number: 37-08415692003

Date of Initial License for Current Owners: 09/01/1970

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2002 to June 30, 2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke LLP, 600 East Adams Springfield IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,789	2,620	1,771	12,180	8
9	SNF/PED					9
10	ICF	7,892	5,515		13,407	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,681	8,135	1,771	25,587	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.81%

D. How many bed-hold days during this year were paid by Public Aid?
167 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 39 and days of care provided 1,771

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	121,215	13,520	6,716	141,451		141,451		141,451			1
2	Food Purchase		128,510		128,510		128,510	(12)	128,498			2
3	Housekeeping	109,860	21,122		130,982		130,982		130,982			3
4	Laundry											4
5	Heat and Other Utilities			68,642	68,642		68,642	3,005	71,647			5
6	Maintenance	31,664	14,494	18,099	64,257		64,257	5,019	69,276			6
7	Other (specify):*											7
8	**TOTAL General Services**	262,739	177,646	93,457	533,842		533,842	8,012	541,854			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	901,188	40,045	4,216	945,449		945,449		945,449			10
10a	Therapy			132,495	132,495		132,495		132,495			10a
11	Activities	33,528			33,528		33,528		33,528			11
12	Social Services	47,837	1,375	4,932	54,144		54,144		54,144			12
13	Nurse Aide Training											13
14	Program Transportation			866	866		866		866			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	982,553	41,420	143,009	1,166,982		1,166,982		1,166,982			16
	C. General Administration											
17	Administrative	87,327		107,534	194,861		194,861	(72,033)	122,828			17
18	Directors Fees											18
19	Professional Services			56,602	56,602		56,602	4,292	60,894			19
20	Dues, Fees, Subscriptions & Promotions			13,665	13,665		13,665		13,665			20
21	Clerical & General Office Expenses	39,650	4,657	2,750	47,057		47,057	56,269	103,326			21
22	Employee Benefits & Payroll Taxes			245,314	245,314		245,314	11,931	257,245			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,767	10,767		10,767	4,066	14,833			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,393	90,393		90,393	1,792	92,185			26
27	Other (specify):*											27
28	**TOTAL General Administration**	126,977	4,657	527,025	658,659		658,659	6,317	664,976			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,372,269	223,723	763,491	2,359,483		2,359,483	14,329	2,373,812			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number La Moine Christian Nursing Home #0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			99,018	99,018		99,018	16,970	115,988			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			439	439		439		439			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			99,457	99,457		99,457	16,970	116,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			46,827	46,827		46,827		46,827			39
40	Barber and Beauty Shops	14,672	325	322	15,319		15,319		15,319			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	14,672	325	101,352	116,349		116,349		116,349			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,386,941	224,048	964,300	2,575,289		2,575,289	31,299	2,606,588			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,513	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,243)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	28,847	21		24
25	Fund Raising, Advertising and Promotional	(679)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(12,743)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 23,683		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	7,616		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,616		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 31,299		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

La Moine Christian Nursing Home

ID# 0005397

Report Period Beginning: July 1, 2002

Ending: June 30, 2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (556)	21	1
2	Activity Revenue	(532)	21	2
3	Loss on Disposal	117	21	3
4	Miscellaneous Income	(411)	17	4
5	Marketing	(11,361)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(12,743)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number La Moine Christian Nursing Home **#** 0005397 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12)	0	0	0	0	0	0	0	0	0	0	(12)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,005	0	0	0	0	0	0	0	0	0	3,005	5
6	Maintenance	0	5,019	0	0	0	0	0	0	0	0	0	5,019	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12)	8,024	0	0	0	0	0	0	0	0	0	8,012	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(411)	(71,622)	0	0	0	0	0	0	0	0	0	(72,033)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,292	0	0	0	0	0	0	0	0	0	4,292	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	14,593	41,676	0	0	0	0	0	0	0	0	0	56,269	21
22	Employee Benefits & Payroll Taxes	0	11,931	0	0	0	0	0	0	0	0	0	11,931	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,066	0	0	0	0	0	0	0	0	0	4,066	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,792	0	0	0	0	0	0	0	0	0	1,792	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	14,182	(7,865)	0	0	0	0	0	0	0	0	0	6,317	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	14,170	159	0	0	0	0	0	0	0	0	0	14,329	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number La Moine Christian Nursing Home **#** 0005397 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,513	7,457	0	0	0	0	0	0	0	0	0	16,970	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,513	7,457	0	0	0	0	0	0	0	0	0	16,970	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	23,683	7,616	0	0	0	0	0	0	0	0	0	31,299	45

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Christian Homes Inc.	100.00%	$	$	1
2	V	5	Utilities				3,005	3,005	2
3	V	6	Maintenance				5,019	5,019	3
4	V	17	Administrative	99,960			28,338	(71,622)	4
5	V	18	Directors						5
6	V	19	Professional Services				4,292	4,292	6
7	V	20	Fees, Subscriptions						7
8	V	21	Clerical				41,676	41,676	8
9	V	22	Employee Benefits				11,931	11,931	9
10	V	23	Inservice Training						10
11	V	24	Travel & Seminar				4,066	4,066	11
12	V	26	Insurnace				1,792	1,792	12
13	V	30	Depreciation				7,457	7,457	13
14	Total			$ 99,960			$ 107,576	$ * 7,616	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: ne 30, 2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	This workpaper is not applicable.											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	190	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	408	2
3. Under or (over) accrual (line 2 minus line 1).	$	218	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	221	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	439	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME La Moine Christian Nursing Home COUNTY Warren

FACILITY IDPH LICENSE NUMBER 0005397

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	7-050-086-00	7-346 S31 T9 R2	$ 66.78	$
2.	7-050-092-00	7-349 S31 T9 R2	$ 72.25	$
3.	7-050-087-00	7-347 S31 T9 R2	$ 66.78	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 205.81	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,150 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	1,360,680	1968	$ 10,992	1
2	Home Office Allocation			4,033	2
3	TOTALS	1,360,680		$ 15,025	3

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		1971	1971	$ 828,269	$ 16,565	40	$ 20,707	$ 4,142	$ 526,053	4
5	37		1975	1975	574,166	11,483	36	15,949	4,466	327,281	5
6			1976	1976	29,531	591	20	1,477	886	16,252	6
7											7
8	Home Office Allocation				29,088	836		836		15,022	8
	Improvement Type**										
9	Building Improvements			1977	2,335	52	33	71	19	1,313	9
10	Windows			1980	8,654	192	45	192		4,462	10
11	Windows			1980	8,415	191	44	191		4,298	11
12	Remodeling			1981	341	8	44	8		176	12
13	Remodeling			1981	2,643	60	44	60		1,324	13
14	Heating Systems			1982	50,515	416	20	416		50,515	14
15	Garage			1982	9,457	378	25	378		7,970	15
16	Furnace			1983	5,889	294	20	294		5,880	16
17	Building Improvements			1983	5,309	123	43	123		2,501	17
18	Blank						35				18
19	Office Remodel			1986	13,549	339	40	339		5,735	19
20	Ventilating Fan			1987	463		10			463	20
21	Floor Tile			1988	2,089		5			2,089	21
22	New Kitchen A/C Pump			1988	1,556	95	15	95		1,551	22
23	Door Monitor			1989	1,170	78	15	78		1,131	23
24	Remodeling			1989	2,901	145	20	145		2,090	24
25	Door Monitor			1989	2,218		10			2,218	25
26	E W SGL Door Monitor			1989	1,057	70	15	70		974	26
27	Fire Alarm System			1990	16,365	818	20	818		10,975	27
28	Conventional Oven			1991	2,510	167	15	167		2,157	28
29	Light Fixtures			1991	395		10			395	29
30	Blank										30
31	Compressor			1992	1,126		10			1,126	31
32	Phone System			1992	623		10			623	32
33	Cubicle Track			1992	2,888		10			2,888	33
34	Hot Water System			1993	13,270	885	15	885		9,145	34
35	Remodeling			1993	5,233		5			5,233	35
36	Wallcoverings/carpet			1994	3,744		5			3,744	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	TV Antennae	1994	$ 4,351	$ 435	10	$ 435	$	$ 3,957	37
38	Flourscent Light Fixtures	1994	608		5			608	38
39	Wallcoverings	1995	1,445		5			1,445	39
40	Remodel 4 rooms	1995	2,862		5			2,862	40
41	Wallpaper	1995	600		5			600	41
42	Flourscent Light Fixtures	1995	908	91	10	91		713	42
43	Egress Locking System	1995	3,252		5			3,252	43
44	Floorcoverings	1995	3,856		5			3,856	44
45	Wallpaper	1995	3,821		5			3,821	45
46	Roof	1996	168,868	11,258	15	11,258		78,806	46
47	Roof Exhaustor	1996	750		5			750	47
48	3 foot Bathroom fixtures	1996	935		5			935	48
49	Wallcoverings	1996	874		5			874	49
50	Vinyl-S Wing Wallway	1996	3,012		5			3,012	50
51	Wallcoverings - 5 rooms	1996	2,946		5			2,946	51
52	Sewer/Garbage Disposal	1996	3,058		5			3,058	52
53	Ceiling Tile Laundry	1997	1,237	124	10	124		734	53
54	Water Softner System	1997	10,033	333	5	333		10,033	54
55	Energy Management System	1997	14,830	1,483	10	1,483		8,404	55
56	Replumb end of N H	1997	14,103	1,410	10	1,410		7,872	56
57	Wallcoverings	1997	985	82	5	82		985	57
58	Dining Room Windows	1997	6,533	653	10	653		3,646	58
59	Remodel Bathroom	1997	2,229	185	5	185		2,229	59
60	Remodel Office	1998	1,696	170	5	170		1,696	60
61	Wallpaper Restroom	1998	3,003	399	5	399		3,003	61
62	Carpet-Lobby	1999	2,566	513	5	513		2,437	62
63	Wallpaper-Hallways	1999	14,431	2,886	5	2,886		13,227	63
64	Motherboards-Fire Alarm	1999	1,385	277	5	277		1,247	64
65	Wallpaper-Restrooms	1999	5,733	1,147	5	1,147		4,588	65
66	Door Locking System	1999	9,490	1,898	5	1,898		7,908	66
67	Windows-Dining Room	1999	7,640	509	15	509		2,163	67
68	Serving Lamps	2000	1,470	294	5	294		1,152	68
69	Entrance Canopy w/Sidewalk	2000	3,577	358	10	358		1,402	69
70	TOTAL (lines 4 thru 69)		$ 1,928,856	$ 58,291		$ 67,804	$ 9,513	$ 1,199,805	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,928,856	$ 58,291		$ 67,804	$ 9,513	$ 1,199,805	1
2	Wallpaper	2000	1,164	233	5	233		835	2
3	Wallpaper	2000	5,430	1,086	5	1,086		3,530	3
4	Light Fixtures	2000	1,039	104	10	104		321	4
5	Seagull Fixture	2000	5,631	563	10	563		1,736	5
6	Deluxe Composite Stool	2000	1,404	140	10	140		432	6
7	Sink (North Port-R Med)	2000	908	91	10	91		349	7
8	Seagull Fixture (8)	2000	856	86	10	86		265	8
9	Floor Base	2000	614	123	5	123		369	9
10	Top Treatment (2)	2000	620	124	5	124		372	10
11	ZONELINE HEAT/ COOL	2000	7,218	481	15	481		1,443	11
12	DOUBLE SWING (51)	2000	1,595	319	5	319		957	12
13	ZONELINE HEAT/ COOL (11)	2000	7,476	498	15	498		1,411	13
14	MATTRESS (6)	2000	775	97	8	97		275	14
15	INSTALLATION OF ALK IN FREEZER	2000	9,498	950	10	950		2,771	15
16	FURNACE HEAT EXCHANGER	2000	1,448	290	5	290		749	16
17	WALLPAPERING SOUTH WING	2001	2,447	489	5	489		1,223	17
18	ENLARGE/REMODEL P.T. ROOM	2001	5,826	583	10	583		1,458	18
19	CABINETS	2001	574	38	15	38		89	19
20	WALK-IN COOLER (DOWN PAYMENT)	2001	5,000	500	10	500		1,125	20
21	10 Store Room Locks	2001	501	100	5	100		200	21
22	WALK-IN COOLER (Final PAYMENT)	2001	4,598	460	10	460		920	22
23	Replacement of Broken Window	2001	625	42	15	42		77	23
24	Interiors Decorations/Nursing Home	2001	506	101	5	101		194	24
25	Carpet - South Wing	2001	9,810	1,962	5	1,962		3,270	25
26	Heat Exchanger	2001	1,598	107	15	107		178	26
27	Remodeling Project/RR #302,303,305	2002	5,228	523	10	523		697	27
28	Kitchen Remodeling/Sink,Counter tops, shelves	2002	2,608	174	15	174		232	28
29	Remodeling Project/Staff Lounge,Beauty Shop	2002	20,771	2,077	10	2,077		2,596	29
30	Remodel Men's Public Restroom	7/19/2002	1,469	147	10	147		147	30
31	Install New Water Line to Dining Room	10/28/2002	1,780	67	20	67		67	31
32	Wanderguard Monitor & Auxiliary Monitor	2/5/2003	821	23	15	23		23	32
33	Rooftop AC unit	5/8/2003	15,680	261	10	261		261	33
34	TOTAL (lines 1 thru 33)		$ 2,054,374	$ 71,130		$ 80,643	$ 9,513	$ 1,228,377	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,054,374	$ 71,130		$ 80,643	$ 9,513	$ 1,228,377	1
2	Install 220V Outlet in Dining Room	5/15/2003	572	5	20	5		5	2
3	Fully depreciated land improvements	6/30/1974	9,358		20			9,358	3
4	Water and sewer work	6/16/1987	20,638	1,004	20	1,004		16,613	4
5	Trees & shrubs	5/23/1991	1,315	66	20	66		803	5
6	Parking lot	6/30/1995	15,426	1,543	10	1,543		12,473	6
7	Resurface lot	9/8/1999	3,500	193	3	193		3,500	7
8	Landscaping and sign	6/1/2000	6,235	624	10	624		1,763	8
9	Gazebo and landscaping	6/4/2001	4,189	419	10	419		861	9
10	Sign	2/5/2002	580	58	10	58		82	10
11	Yard barn	9/30/1993	500		5			500	11
12	Bus barn	10/24/1995	12,815	641	20	641		4,274	12
13	Overhead door opener	6/3/2002	726	73	10	73		79	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Less: Disposals		(1,556)					(1,551)	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,128,672	$ 75,756		$ 85,269	$ 9,513	$ 1,277,137	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 187,230	$ 21,755	$ 21,755	$	Various	$ 114,975	71
72	Current Year Purchases	29,599	2,343	2,343		Various	2,343	72
73	Fully Depreciated Assets	155,680				Various	155,680	73
74	Home Office Allocation	50,482	5,345	5,345			27,949	74
75	TOTALS	$ 422,991	$ 29,443	$ 29,443	$		$ 300,947	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1979 GMC Van	1979	$ 10,311	$	$	$	5	$ 10,311	76
77	Patient Transportation	1994 Ford Bus	1994	44,700				8	44,700	77
78										78
79	Home Office Allocation			5,816	1,276	1,276			2,669	79
80	TOTALS			$ 60,827	$ 1,276	$ 1,276	$		$ 57,680	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,627,515	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,475	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,988	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,513	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,635,764	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 79,603	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 79,603	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number La Moine Christian Nursing Home **#** 0005397 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 368,457	$	1
2	Cash-Patient Deposits	19,962		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,946)	321,832		3
4	Supply Inventory (priced at FIFO)	14,840		4
5	Short-Term Investments	324,473		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Acc Int Rec/Other Rec	5,183		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,054,747	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	90,594		13
14	Buildings, at Historical Cost	2,038,340		14
15	Leasehold Improvements, at Historical Cost	61,238		15
16	Equipment, at Historical Cost	427,519		16
17	Accumulated Depreciation (book methods)	(1,590,124)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	395,661		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP/Land Improvement	550		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,423,778	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,478,525	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 58,876	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,962		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,750		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	221		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 201,809	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 201,809	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,276,716	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,478,525	$	48

***(See instructions.)**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,244,235	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,244,235	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,481	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 132,481	17
	B. Transfers (Itemize):		
18	**Transfer Out to Affiliate**	(100,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (100,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,276,716	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,911,407	1
2	Discounts and Allowances for all Levels	(423,218)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,488,189	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(1,088)	12
13	Barber and Beauty Care	18,010	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 16,922	23
	D. Non-Operating Revenue		
24	Contributions	169,600	24
25	Interest and Other Investment Income***	32,892	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 202,492	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investmenst/Sale of Equipment	(82)	28
28a	Miscellaneous	249	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 167	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,707,770	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	533,842	31
32	Health Care	1,166,982	32
33	General Administration	658,659	33
	B. Capital Expense		
34	Ownership	99,457	34
	C. Ancillary Expense		
35	Special Cost Centers	62,146	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,575,289	40
41	**Income before Income Taxes (line 30 minus line 40)****	132,481	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 132,481	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,467	1,549	$ 39,248	$ 25.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,175	6,585	134,103	20.36	3
4	Licensed Practical Nurses	13,472	13,857	179,174	12.93	4
5	Nurse Aides & Orderlies	43,765	45,037	509,303	11.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,256	3,358	39,360	11.72	8
9	Activity Director					9
10	Activity Assistants	2,525	2,635	33,528	12.72	10
11	Social Service Workers	3,425	3,584	47,837	13.35	11
12	Dietician					12
13	Food Service Supervisor	1,875	2,004	24,243	12.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,702	11,216	96,972	8.65	15
16	Dishwashers					16
17	Maintenance Workers	1,556	2,350	31,664	13.47	17
18	Housekeepers	10,547	10,851	109,860	10.12	18
19	Laundry					19
20	Administrator	1,905	1,930	87,327	45.25	20
21	Assistant Administrator					21
22	Other Administrative	1,120	1,207	15,314	12.69	22
23	Office Manager	1,847	1,995	24,336	12.20	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,089	1,129	14,672	13.00	33
34	TOTAL (lines 1 - 33)	104,726	109,287	$ 1,386,941 *	$ 12.69	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	142	$ 6,716	1.3	35
36	Medical Director	96	500	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	95	2,079	10.3	39
40	Physical Therapy Consultant	1,099	72,319	10A.3	40
41	Occupational Therapy Consultant	856	54,954	10A.3	41
42	Respiratory Therapy Consultant	5	65	10A.3	42
43	Speech Therapy Consultant	71	5,157	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	59	4,495	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,423	$ 146,285		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Gutermuth	Administrator	0	$ 73,470
Wirt L. Thompson	Administrator	0	13,857
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,327

B. Administrative - Other

Description	Amount
Management Fee	$ 99,960
Other administrative expenses	6,914
Leasing fee	660
TOTAL (agree to Schedule V, line 17, col. 3)	$ 107,534
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Recruiters	Staffing Service	$ 18,522
FR & R Healthcare	Consulting	990
Van Ostrand	Legal	108
Melotte-Morse	Architects	2,750
VP Circle of Quality	IOC Audit & Training	19,868
Management Performance Assoc	Consulting	14,364
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 56,602

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,880
Unemployment Compensation Insurance	3,600
FICA Taxes	100,996
Employee Health Insurance	104,250
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	576
Other Employee Expense	2,053
W C Medical Expense	959
Home Office Allocation	11,931
TOTAL (agree to Schedule V, line 22, col.8)	$ 257,245

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,176
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	4,701
Subscriptions	175
Software support fees	4,412
Other Miscellaneous fees	1,201
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,665

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 207
In-State Travel	3,894
Seminar Expense	5,186
Miscellaneous	1,480
Home office Allocation	4,066
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,833

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2002 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $4,701**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,157** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

LaMoine Christian
Allocation on Benefits 6/30/2003 kdb
11/4/2005

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	W C Med Expense	Benefit Percentage	Employee Uniforms	Employee Expense	Employee Physicals	
65,864.97	2,352.00	21,468.00	67,500.00						
9,381.64	420.00	3,816.00	4,500.00		3,717.30				
7,302.41	360.00	3,204.00	6,000.00		4,381.06				269,871.47
2,651.64	72.00	708.00	6,750.00		1,811.42				
6,501.59	192.00	1,800.00	9,000.00		4,594.87				
8,326.16	168.00	1,584.00	6,000.00	958.70	9,046.66	-761.93	2,813.07	576.00	
968.08	36.00	300.00	4,500.00		1,007.83				
100,996.49	3,600.00	32,880.00	104,250.00	958.70	24,559.14	-761.93	2,813.07	576.00	269,871.47

Less Benefits: 24,559.14
Line 3.22.3 245,312.33

C:\DATAload\[La Moine Christian Nursing H-2003-0005397.xls]PG1